



# Managing Acute Pain in a Heroin Addict: Discussion of four cases

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# Objectives

- Relate ethical principles to patients with substance use disorders
- Through presentation of the case studies, be able to state situations when active heroin users need appropriate pain management
- Summarize general guidelines in the management of pain in a patient with active addictive disease
- Federal law - limitations
- Discuss four factors that contribute to the stigma associated with opioid use disorder and its treatment (MAT)



# American Society for Pain Management Nursing Position Statement: Pain Management in Patients with Substance Use Disorders

**“...that patients with substance use disorders and pain have the right to be treated with dignity, respect, and the same quality of pain assessment and management as all other patients.”**



# Ethical Principles/Issues

## **Beneficence and Justice**

Requires care be delivered in the patient's best interest. Demand that all persons have equal access to effective pain treatment; treated with the same level of vigilance, dignity, and respect

## **Nonmaleficence**

“First do no harm” when a patient's substance use problem raises concerns about potential misuse that results in harmful consequences. Simply discharging the patient from care without appropriate transfer of care/referral may lead to harm.



# Case I

AM is a 40 yom with history of current IV heroin use admitted after complaints of severe back pain following a fall. Found to have L5-L6 diskitis with paraspinal and epidural abscess on MRI and was taken for laminectomy and drainage of the abscess.

- Orthopedics found him to have septic wrist (R), sternoclavicular joint (L), and shoulder (L)
- Hepatitis C antibody positive, HIV negative
- Plan for 6 weeks of IV antibiotics (approximately 54 days)



## Case II

BH is a 37 yom admitted to the hospital found to have strep endocarditis with septicemia secondary to active IV heroin use.

Complications developed during hospitalization:

DVT, acute renal failure, peritonitis, infectious aortic regurgitation, and ischemic bowel disease (embolic phenomenon of strep endocarditis) which led to excision of his small bowel with a portion of the large colon



## Case II continued

- Underwent aortic valve replacement surgery 6-2015
- Tested positive for Hepatitis C antibody
- Continued to require IV nutrition and hydration from short gut syndrome
- Acute hospitalization = 85 days

LL is a 33 yof with a complicated history of polysubstance abuse including cocaine and IV heroin causing MRSA bacteremia which progressed to a brain abscess.

- Patient signed out of the hospital AMA multiple times
- Finally returned due to severe headache – neurosurgery drained the abscess x 2, followed by weeks of iv antibiotics
- Acute hospitalization (approximately) 66 days





## Case IV

RD is a 25 yom admitted to the hospital initially for strep endocarditis of the mitral valve secondary to IV heroin use that led to septic embolic strokes. Was discharged after 8 day stay to complete a 6-week course of IV antibiotics, then follow-up for valve replacement surgery.

- Appropriately placed in methadone treatment, but found unconscious in his home 3 weeks later – ventricular arrhythmia induced by methadone. Coded again in the hospital



## Case IV continued

- Underwent emergency bioprosthetic valvular repair
- Chronic hepatitis C; HIV negative
- Total inpatient hospital days 38



# Interface Between Addiction and Pain

Addictive disease appears to augment the experience of pain



Evidence suggests that people with addictions have decreased pain tolerance

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Reorganization of baseline perceptual pathways in the brain that results in increased pain perception



# Dosing

Addicts, especially opioid addicts, often require larger opioid doses and more frequent dosing intervals than nonaddicted patients to adequately control their pain.



# Basic Principle #1

Acute pain is a medical emergency and should be treated as such.

Opioid withdrawal symptoms can interfere with attempts to control pain. The time for detoxification is not when pain management is needed but rather when opioids are no longer medically indicated.



## Basic Principle #2

- Chose the medication needed for pain relief according to WHO guidelines. Reassure the patient the staff is committed to providing aggressive and effective pain relief.
- Provide pain relief around-the-clock and titrated to a level that provides adequate pain control.



## Basic Principles #3 and #4

- Avoid mixed opioid agonist/antagonists for analgesia because withdrawal will be precipitated and pain will increase
- The “high” that addicts achieve from opioids is directly proportional to the rate at which the concentration of the drug rises in the blood - - intermittent IV bolus doses enhance the rewarding effects of the drug



## Basic Principle #5

- Intravenous administration of opioids is less rewarding when administered as a continuous infusion
- When pain is anticipated 24/7 - - do not just use “prn dosing”
  - Opioid continuous infusion
  - Opioid PCA
  - Long-acting oral opioid
  - Fentanyl patch
- Structured control – fixed intervals of short acting oral medications





# Basic Principle #6

- Opioid withdrawal can be avoided by administering a baseline dose of opioid that corresponds to the patient's usual opioid use; then supply additional opioids to address the pain.
- Develop this plan **WITH** the patient – provide them with a written copy



# Basic Principle #7

- Care of addictive disease and pain is complex and ideally would be undertaken in a multidisciplinary manner, however not always possible. All clinicians are encouraged to learn how to treat pain in actively using patients.
- To prevent relapse - - incorporate addiction professionals to provide a recovery-related support system (psychiatric support, counseling, CBT, providing a sponsor, etc).




# Goals

Acute pain management	Acute pain management in a current addict
Minimize the physiologic adverse effects of uncontrolled pain	Prevent withdrawal
Avoid adverse effects	Prevent relapse to addiction
Maximize nonpharmacological treatment approaches	Achieve pain scores 2-5 / 10
Achieve pain scores 2-5 / 10	Address additional psychiatric issues, such as anxiety



# Prevent Relapse

- Initiate treatment for addiction (counseling)
- Psychiatry consult – to address co-mental illness
- Discharge plan to include:
  - plan for medication-assisted treatment (MAT)
  - Opioid overdose education
  - Naloxone distribution



Clinical Research Study: *The American Journal of Medicine* (2016) 129, 481-485.


Retrospective study: 102 patients at tertiary medical center in Boston admitted with endocarditis and drug abuse.

Primary Outcome: assess the interventions for addiction during their hospitalization



# Results

Found that the treatment of patients with injection drug use associated infective endocarditis was largely focused on management of the infectious process and that interventions addressing addiction in these patients was lacking.



		Sentinel Admission (n=102)	Readmissions (n=131)
Inpatient Consults:			
	Social Work	82/95	66/123
	Addiction Clinical RN	22/93	9/122
	Psychiatry	23/96	12/123
Discharge Planning:			
	Discharge Summary	57/102	30/131
	Plan for MAT	8/102	18/131
	Narcan Rx	0/102	0/131



# Addiction Information

Lookupindiana.org

Centers for Behavioral Health on Lima Rd

Opening 12-2016 - -

CleanSlate on 3103 E State St






# Barriers

Health Care providers have:

- “Opiophobia” - fear of legal repercussions for overprescribing opioids
- Feeling they are “feeding the addiction”
- Addiction is a moral weakness
- Views that the patients don’t deserve care; should be punished
- Attitudes of distrust of pain patients, especially the patient with a history of substance use disorder
- Time limits – treatment of pain in an individual with a co-occurring addiction is time-consuming and stressful for the physician



Many barriers – who is going  
to be responsible for the care of  
these patients?



Pasero C and McCaffery M. *Pain Assessment and Pharmacologic Management*. St. Louis, MO: Mosby, Inc; 2011. Page 530

A pain specialist speaking about co-existing pain and addictive disease to an audience of other pain specialists received this comment from a member of the audience, “These patients are too difficult, take up too much time, and put me in legal jeopardy. I simply have to discharge them from my practice.”

**“If we, the pain specialists, don’t treat them, who will?”**